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Office of Administrative Law Judges
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CASE NO.: 2000-LHC-1764

OWCP NO.: 07-145683

IN THE MATTER OF:

GENE A. WILSON

Claimant

v.

NABORS OFFSHORE CORPORATION

Self-Insured Employer¹

APPEARANCES:

JOHN MICHAEL MORROW, JR., ESQ.
JAMES GATES, ESQ.

For The Claimant

KEVIN A. MARKS, ESQ.

For the Self-Insured Employer

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

¹ The Employer's name appears as amended at hearing.
(Tr. 4-5).

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Gene A. Wilson (Claimant) against Nabors Offshore Corporation (Self-Insured Employer).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on October 17, 2000, in Metairie, Louisiana. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered 14 exhibits, Employer proffered 20 exhibits which were admitted into evidence along with one Joint Exhibit. This decision is based upon a full consideration of the entire record.²

Post-hearing briefs were received from the Claimant, Employer and the Regional Solicitor on behalf of the District Director. Claimant filed a rebuttal memorandum on January 16, 2001. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. That Claimant was involved in an "incident" on May 11, 1999.
2. That Claimant's "incident" occurred during the course and scope of his employment with Employer.
3. That there existed an employee-employer relationship at the time of the "incident."
4. That the Employer was notified of the "incident" on May 11, 1999.

² References to the transcript and exhibits are as follows: Transcript: Tr.____; Claimant's Exhibits: CX-____; Employer's Exhibits: EX-____; and Joint Exhibit: JX-____.

5. That Employer filed a Notice of Controversion on October 20, 1999.

6. That an informal conference before the District Director was held on January 26, 2000.

7. That Claimant has received no disability benefits.

8. That no medical benefits for Claimant have been paid pursuant to Section 7 of the Act.

9. That Claimant's average weekly wage at the time of his "incident" was \$509.60.

II. ISSUES

The unresolved issues presented by the parties are:

1. Causation: Whether Claimant suffered an injury from a work-related accident on May 11, 1999. (Tr. 20-22).

2. Nature, extent, and duration of Claimant's injuries, if any.

3. Claimant's entitlement to temporary total disability benefits.

4. Whether Claimant is in need of and entitled to medical treatment.

5. Claimant's wage earning capacity, if any.

6. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Claimant testified at the hearing and also through deposition. (EX-T). He was 39 years of age at the time of the hearing. (Tr. 35). He has a seventh grade formal education and professed to be a very poor student. He can read and write "a

little bit."³ He received vocational training in auto mechanics, but was not awarded a diploma or certificate. (Tr. 36-37). His past vocational history is farming and oil field work, as a roustabout, mudworker and roughneck, which he stated were heavy, hard jobs. (Tr. 37-39).

He began with Employer as a roustabout and after six months was promoted to roughneck or "shakerman," which required heavy lifting and pulling and pushing slips and pipes. (Tr. 40-41). He worked 14 days on and 14 days off, twelve hours a day at \$12.42 per hour. (Tr. 41). He worked 44 hours of overtime per shift and participated in a dental plan, health insurance and a 401(k) retirement plan. (Tr. 42). He testified that he liked his job and planned to stay with the Employer. He was in good health before his accident and had passed a pre-employment physical for Employer. He had not missed any work because of back or hip problems. He testified that he had never injured his back or neck before his work accident. (Tr. 43-44).

He acknowledged being involved in two auto accidents; the first in 1994 when he hurt his chest and in 1995 when he hurt his finger, chest and hip. He did not miss any work because of his auto accident injuries. (Tr. 44-45). He received workers' compensation when he injured his shoulder while an employee of Penrod Drilling. (Tr. 46).

Claimant testified he was working on the Chevron Genesis platform for Employer when he suffered an accident/injury that gave rise to this claim. He was descending from a trough onto a ladder, wearing a safety harness, when the ladder slid from under him and caused him to "spring up" into the trough hitting his back and hip. He was left hanging by his safety lanyard/harness for about five minutes. (Tr. 47-48). He stated he felt immediate pain in his back and hip. He was given Motrin and filled out an accident report with Tim Barnes, the safety man/medic. (Tr. 49, 53; CX-4). Claimant only worked light duty for the remainder of the day. He was transported off the rig

³ In deposition, he stated that he does not currently possess a valid driver's license because it expired and he has not been able to pass the written part of the driver's license examination. (EX-T, page 9). He can sign his name. He stated he reads the Bible and can do "a little bit" of adding and subtracting, "not much." (EX-T, p. 14). He understands "the way money works," and can make change. (EX-T, p. 15).

the following morning when he complained of continual "hurting" in his back and hip. He stated he also told Mr. Barnes that his neck was hurting. (Tr. 52). He was picked up at Fouchon, Louisiana by Vickie, a representative of Employer, and taken to Dr. Cenac's office whom Employer selected for his treatment.⁴ (Tr. 53-54).

Claimant testified his lower back, hip and neck were hurting and his "leg was getting numb" when first examined by Dr. Cenac. Dr. Cenac performed x-rays, checked him out and told him he could return to the rig. (Tr. 54). He returned to the rig and tried to work, but continued to hurt. He informed Mr. Barnes and the toolpusher of his pain and was again transported to Fouchon. (Tr. 55). On this occasion, a man picked him up and brought him to Dr. Cenac's office. Dr. Cenac placed Claimant on light duty and ordered an MRI, a bone scan and prescribed pool therapy. (Tr. 57). Claimant remained at the Employer's Houma, Louisiana yard performing light duties, such as washing dishes and sweeping, through the end of his hitch. (Tr. 56). At the end of his hitch, Claimant was brought to Fouchon to pick up his car and drove home to Ville Platte, Louisiana, which took him longer than usual because he had to stop often. (Tr. 58).

While on his days off, Claimant sought medical treatment from Dr. Tassin, his family doctor, who took him off all work and prescribed pain medicine. (Tr. 58-59). Claimant testified he called Employer and thinks he spoke to Vickie who was informed Dr. Tassin told him not to go back to work and that he "wouldn't be going back to the yard in Houma because of the driving and of my pains." (Tr. 59). Vickie told Claimant he "had to come back to the yard."⁵ Claimant told Vickie he was not

⁴ A dispute exists concerning who accompanied Claimant to the doctor on his two visits with Dr. Cenac. Ms. Duplantis credibly stated she attended the first visit and Ms. Vickie Larke accompanied Claimant to the second exam.

⁵ In deposition, Claimant acknowledged that Employer informed him that he would be terminated if he did not participate in the light duty program. He decided not to return to Houma and the light duty program, because "I couldn't make it to Houma." (EX-T, p. 50). Dr. Tassin informed him that he shouldn't be driving to Houma because "it was too long a ride." (EX-T, p. 51). Ms. Larke and Ms. Duplantis deny Claimant's alleged contact with Employer about

ready to return and testified he was then fired. (Tr. 60).

Dr. Tassin referred Claimant to a specialist, Dr. Lorio. When he was examined by Dr. Lorio, Claimant's back and hip were hurting and he had some numbness in his leg. (Tr. 61). Dr. Lorio also took Claimant off roughnecking work, prescribed pain medicine and physical therapy. (Tr. 61-62). Claimant attended physical therapy for three months with Sandra Mullins in Ville Platte. (Tr. 62). He continues to treat with Dr. Lorio who recommended testing for his neck problem which was conducted at Opelousas General Hospital. (Tr. 63). Dr. Lorio released Claimant to perform light duty work on January 31, 2000. (Tr. 65).

Claimant testified he underwent a functional evaluation by Ms. Mullins which occurred on two separate days. After the evaluation, Dr. Lorio recommended additional physical therapy which Employer would not authorize. (Tr. 66).

Presently, Claimant still has problems with his back, hip and leg numbness. (Tr. 66-67). Because of his leg weakness, he stated he began using a cane. He testified that "sometimes I limp and sometimes I don't." He has good days and bad days. His symptoms are made worse by bending, kneeling and lifting something too heavy. Pain medicine makes his symptoms better. He is able to cut the grass with a lawnmower. (Tr. 67).

He stated that he is not able to return to work as a floorhand because he is still in pain and hurting. He testified that he could not pull the slips, which is real heavy work, or perform the lifting requirements. The heaviest objects lifted since his job accident have been speakers which weigh 18.5 pounds. (EX-T, p. 58).⁶ He has not return to any work. (Tr. 68-69). He acknowledged that he has performed odd jobs, "general repair work," for his landlord in exchange for rent of his house. (Tr. 69; EX-T, pp. 15-16).⁷ He denied telling anyone

being taken off work by Dr. Tassin before his discharge.

⁶ In deposition, Claimant denied ever lifting his lawnmower which he estimates weighs "a little more than the speakers." (EX-T, p. 69).

⁷ In deposition, Claimant denied working in any situation for cash or a paycheck. (EX-T, p. 17). Subsequently, he

at the Employer that he was going to fake any injury and did not fake his injury.⁸ (Tr. 70).

On cross-examination, Claimant reaffirmed that he has not worked at all since leaving Employer. He also testified he had not worked for "cash under the table." He acknowledged he had performed physical work in exchange for rent around his house.

Inconsistently, he further recalled doing disc jockey work for cash. He has not looked for any jobs since his job accident or his release by Dr. Lorio. (Tr. 72).

Claimant reaffirmed that he had no problems with his back, hip or legs before his job accident. (Tr. 73).⁹ He was aware Dr. Tassin's records revealed he also hurt his right hip and complained of low back and right leg pain after his 1995 auto accident. He admitted he did not testify to the additional injuries about his back and leg on direct examination, notwithstanding a direct query from the undersigned about the injuries he suffered from the accident. (Tr. 74-75). He acknowledged he told the toolpusher on the rig that his back was bothering him before his job accident, but not from a job injury. (Tr. 76-77). Claimant sought treatment with Dr. Tassin who diagnosed a kidney problem. (Tr. 77). He denied telling anyone a few days before his job accident that his back was hurting. (Tr. 78).

Claimant can read some things, such as the newspaper on

acknowledged he performed "D.J. work" on the side for \$50.00 cash per day, but not often. (EX-T, p. 59). He denied performing any repairs to the outside of buildings, either at his house or any other place. (EX-T, p. 58).

⁸ Wheat did not testify that Claimant reported he was going to stage an accident and injury. Wheat's conclusions are based on speculation from a conversation at an unspecified time before Claimant's alleged accident. I do not rely upon Wheat's testimony regarding Claimant's alleged motivation against Employer.

⁹ In deposition, Claimant denied any problems with his neck, back, hip, legs or with headaches before the instant job accident. He also confirmed that he never had any injuries to any of the foregoing body parts before his job accident. (EX-T, pp. 65-66).

occasion and the Bible, and can do "a little bit" of adding and subtracting. He can make change. (Tr. 78).¹⁰

Claimant denied being angry about having to pressure wash or scrub the rig and denied complaining about such tasks. (Tr. 80-81). He further denied commenting to anyone to the effect that Employer "shouldn't be messing with me, and I shouldn't have to be doing this." (Tr. 81).

Regarding his job accident, he testified he fell about ten or eleven feet, his feet barely touching the ground before he was "snapped back" up five or six feet hitting his right side and lower back. (Tr. 83-84). He immediately felt back and hip pain and reported his pain. (Tr. 85). He stated he reported lower back and hip pain to Mr. Barnes on the day of the accident. (Tr. 86). When the incident report was completed on the following day, only right hip pain was noted. Claimant stated he first complained about his neck pain the morning following his accident but after his incident report was filled out. He also testified he complained to Dr. Cenac about his neck pain, although the examination reports reveal no such complaints. (Tr. 87-89).

Claimant's last day of work for Employer was May 23, 1999, and he "understood that [he was] to report back to light duty on or about May 31, 2000 (sic)." He acknowledged that he did not report back for his light duty assignment. (Tr. 97).

Claimant further stated that he has performed housework such as cooking, cleaning and dusting; is able to do shopping, laundry and gardening; changed the alternator on his car; and participates in social activities such as trail riders, church activities and dancing. (Tr. 100-101). He has gone fishing once or twice since his injury, carries 18.5 pound speakers for his disc jockey work and lifts his lawnmower in and out of his car trunk. (Tr. 102). In deposition, he stated he could not lift his lawnmower and denied having done so, which at hearing he acknowledged was not true. (Tr. 102-103). Claimant further acknowledged that he was untruthful when he testified in deposition that he had not performed any repairs on any buildings outside. (Tr. 106).

¹⁰ In deposition, Claimant denied an ability to read a newspaper. (EX-T, p. 14).

On October 5, 2000, Claimant was surveilled and filmed after his deposition, but did not display a limp. He was also filmed carrying two full five-gallon plastic jugs of water, one in each hand, but was not limping.¹¹ (Tr. 110-111). Claimant stated that he did not have any back pain as a result of either his 1994 or 1995 auto accidents. (Tr. 118).

Stephen P. Wheat

Stephen Wheat has worked as a derrickman for Employer for the last three years. (Tr. 121). He worked in the same drill crew as Claimant. He knows Claimant but did not witness his work accident. (Tr. 122).

He testified he had a conversation with Claimant "pretty close" to the time of Claimant's accident when he was assigned to scrub and perform general clean-up. He recalled Claimant stating he "didn't feel like he ought to be scrubbing, and stuff, you know, because he was a shakerman." Mr. Wheat stated they were both angry with the company because the workers were being asked to do a lot more than they were ordinarily asked to do. (Tr. 124). Claimant further stated that "he had already told the medic that he was having problems with his back, and that if they didn't lay off of him, he was going to show them . . . wait and see."

He testified after the conversation, during the same hitch, he learned of Claimant's accident. He admitted he was not positive of the exact amount of time which had transpired after the conversation, but acknowledged "that's the first thing that came to his mind was he just told me he was going to do that." (Tr. 125).

On cross-examination, he stated he was not friends with Claimant and did not ride to and from work with Claimant. (Tr. 126). He admitted having five DWI convictions, but had a driver's license. (Tr. 127). He acknowledged that Claimant never informed him he was going to fake an accident. (Tr. 128-129). He informed "other people" of his conversation with Claimant, but never talked to Claimant after this accident.

¹¹ Official notice is taken of the fact that one gallon of water in a plastic container weighs 8.5 pounds. Thus, for purposes of this decision, a five-gallon jug would weigh approximately 42.5 pounds.

(Tr. 130-131).

Sue Duplantis

Ms. Duplantis is employed by F. A. Richard as the program manager for Employer's workers' compensation claims. (Tr. 133). She previously worked for Employer as claims manager. Her duties included processing and monitoring all claims and overseeing the Transitional Education Program (TEP)(light duty program). (Tr. 134-135). The program's goal is to try to keep workers on their same work schedule and pay scale, but to facilitate a worker's care and return to full duty. (Tr. 135). Claimant was offered and participated in the TEP program for five days. (Tr. 136).

Ms. Duplantis testified that on May 14, 1999, she dispatched Mr. Jacob Lecompte to Fouchon, Louisiana to pick up Claimant after he was transported from the rig. Claimant was brought to Dr. Cenac's office where Ms. Duplantis met Claimant. The history communicated by Claimant to Dr. Cenac's nurse was that he had right hip and low back pain. Claimant did not complain of any neck pain. (Tr. 137). Dr. Cenac's exam was normal, x-rays were normal and he felt Claimant could return to full duty. Claimant returned to the rig.

On May 18, 1999, Ms. Duplantis learned that Claimant was continuing to complain and needed to be sent back to Dr. Cenac. On this occasion, Mr. Blair Michel was dispatched late in the day to pick up Claimant and bring him to a hotel for an overnight stay. Ms. Vickie Larke picked up Claimant at the hotel and transported him to Dr. Cenac's office the next day. (Tr. 138). Dr. Cenac again examined Claimant who complained of right hip and low back pain. The exam was considered normal. Claimant did not complain of a cervical injury. Dr. Cenac ordered a bone scan and MRI and placed Claimant on light duty until the tests were completed. (Tr. 139-140).

Claimant was brought to the TEP yard where he performed galley work and "some paper projects" assembling manuals. (Tr. 140). Ms. Duplantis stated she was informed the diagnostic testing was completely normal. (Tr. 141). Claimant completed his hitch at the TEP yard and was to return to light duty on May 31, 1999. The TEP program is structured on a seven day on-seven day off schedule. (Tr. 146). Claimant did not report back to the TEP yard and did not call-in to Ms. Duplantis or Mr. Ralph Bates, the TEP supervisor. (Tr. 142). On May 31, 1999,

Claimant was considered a voluntary termination since he did not return to his job assignment as scheduled. (Tr. 143). Ms. Duplantis considered Claimant's claim as a "medical-only claim" since he had no lost work time. (Tr. 144).

Employer denied Claimant's claim because his exams with Dr. Cenac were considered normal, the validity of his complaints were questioned by Dr. Cenac, surveillance showed Claimant could do things he stated he could not do and it was concluded that Claimant was not being forthright in his complaints. (Tr. 148). Employer did not pay the medical expenses associated with Claimant's alleged cervical injury because the accident report indicated no cervical injury and he was seen twice by Dr. Cenac, but did not complain about a cervical injury. (Tr. 145). Ms. Duplantis testified that the opinions of Drs. Tassin and Lorio were considered but discounted because their opinions were based upon Claimant's subjective complaints. She further stated that Dr. Cenac's findings were validated by Dr. Bunch's functional capacity evaluation. (Tr. 149).

On cross-examination, Ms. Duplantis confirmed that authorization was given for Dr. Tassin to treat Claimant's back and right hip on or about November 25, 1999. (Tr. 157). She testified the fact that Claimant may have suffered a prior back injury was not considered in denying Claimant's instant claim for compensation benefits. (Tr. 159). She stated Claimant was terminated on May 31, 1999. When she signed and approved the termination notice on June 15, 1999, she was then aware he had been placed on no work status by his family doctor. (Tr. 162-164; EX-K, p. 2).

Ms. Duplantis testified that less credence was given to the reports and opinions of Drs. Tassin and Lorio because they were based on Claimant's subjective complaints and Claimant was not being forthright with his doctors about what he could and could not do in view of surveillance conducted on June 15, 1999, which showed he was active. (Tr. 167-168). Ms. Duplantis testified, after a review of all documents submitted to her, that she believed Claimant could perform the light duty work made available to him by Employer. (Tr. 170). She further confirmed there is no evidence in Claimant's file indicating that his termination was communicated to him on May 31, 1999. Further, there is no written evidence that Claimant was instructed to return to light duty on May 31, 1999, rather than being off his normal two-week hitch schedule. (Tr. 170-171). She was not aware of any driving restrictions placed on Claimant by Dr.

Tassin. (Tr. 171).

On re-direct examination, she stated Claimant's termination was considered voluntary when he did not report for work on May 31, 1999. (Tr. 173-174). She did not actually approve the termination until June 15, 1999. (Tr. 174).

Vickie Larke

Ms. Larke was a claims representative for Employer under the supervision of Ms. Duplantis in May 1999. (Tr. 176-177). Her first contact with Claimant occurred on May 19, 1999, when she was assigned to pick him up at the Plantation Inn and transport Claimant to his second visit with Dr. Cenac. (Tr. 177-178). She stated she was in the examination room during Claimant's examination by Dr. Cenac. Afterwards, she transported Claimant to TEP because Dr. Cenac released Claimant to light duty. (Tr. 179). She testified Claimant was "complaining a lot, walking with a limp, making faces, indicating extreme pain, complaining of his hip, his back." (Tr. 178). She affirmed Claimant did not complain about any neck pain. (Tr. 179).

On one occasion, while on light duty, she observed Claimant walking from the office to the living quarters, "when he thought no one was looking, or didn't know anyone was looking . . . and he was walking totally normal." (Tr. 180).

After Claimant's hitch which included light duty at the TEP, she could not recall receiving a telephone call or any writing from Claimant regarding his visit to Dr. Tassin. (Tr. 181).

On cross-examination, she acknowledged that she had no personal knowledge of any Employer efforts to contact Claimant between May 23, 1999, his last day of work, and May 31, 1999, when he was officially terminated. (Tr. 182). She affirmed having a telephone conversation with Dr. Tassin's office on May 25, 1999, in which authorization and verification of financial responsibility by Employer was approved for treatment to the low back and right hip of Claimant. She testified she was "not sure" if Dr. Tassin's office was questioned about Claimant's status on May 25, 1999. (Tr. 183).

The Medical Evidence

Dr. Christopher E. Cenac

Dr. Cenac, a board-certified orthopedic surgeon, was deposed by the parties on September 28, 2000. (EX-P). At Employer's request, he examined Claimant on May 14, 1999. Dr. Cenac's notes reflect that Claimant complained of pain in his low back and right hip. (EX-P, pp. 6-7).

On physical examination, Dr. Cenac observed no bruises or contusions on Claimant's hip or spine. Dr. Cenac noted tenderness about the anterior superior iliac crest but no evidence of abrasions or contusions. (EX-B, p. 15). Claimant was complaining of "rather significant pain and discomfort," but his neurological evaluation was normal as was his hip exam. (EX-P, p. 8). Radiologic studies of the hip, pelvis and lumbar spine revealed calcification about the acetabulum of the pelvis which Dr. Cenac opined would be consistent with an old injury and not recent trauma. He asked Claimant about prior injuries, but Claimant denied any prior history of injury. There was no evidence of recent trauma and "everything was normal." Id. Dr. Cenac concluded there was no evidence of injury from the alleged work accident and Claimant could return to his full duty employment on the rig. Claimant had no injury and therefore no impairment. (EX-P, p. 9).

On May 19, 1999, Claimant returned to Dr. Cenac complaining of numbness in his right foot and increasing low back pain. Dr. Cenac opined that the "magnitude and intensity of his subjective complaints could not be substantiated by any objective physical findings." Id. Specifically, Dr. Cenac testified Claimant had normal neurological findings, normal mechanical findings, normal straight leg raise findings, his hip exam was normal and there was no evidence of any anatomical reason to substantiate why Claimant was complaining of his significant difficulties. (EX-P, p. 10).

Dr. Cenac stated he gave Claimant the benefit of the doubt and scheduled a bone scan and MRI, two purely objective tests, for May 20, 1999. The bone scan and MRI were normal evidencing "no evidence of trauma to the body, soft tissue or skeletal." (EX-9, p. 5). On May 21, 1999, Dr. Cenac informed Claimant of the normal results from the studies and told him he could return to work in a "progressive fashion." Claimant informed Dr. Cenac that he was not going back to his regular work. (EX-P, p. 11).

Dr. Cenac testified he believed Claimant's complaints to be suspect and that he was malingering. (EX-P, pp. 12-13). Dr. Cenac released Claimant to light duty, but did not believe Claimant had any objective disability or injury. (EX-P, p. 13).

On July 23, 1999, Dr. Cenac prepared a report after reviewing Dr. Tassin medical records. (EX-B, p. 5). He confirmed that Claimant only complained about a low back and right hip injury as a result of his job accident when examined by Dr. Cenac. There were no complaints of a neck injury. Dr. Cenac further noted that Claimant's medical records from Dr. Tassin were inconsistent with his own in that it revealed a car accident in "November 1996" wherein Claimant injured his low back and right hip, thus accounting for the calcification in the hip shown on x-rays. (EX-P, pp. 14-15).

On July 27, 1999, Dr. Cenac prepared a report after reviewing Dr. Lorio's medical records of Claimant. He confirmed that Claimant never complained of any problems with his cervical spine or his left leg. (EX-B, p. 4).

On February 15, 2000, Dr. Cenac reported that he reviewed the cervical myelogram and CT study post-myelogram completed on January 24, 2000, which were normal. He again confirmed that diagnostic testing revealed no evidence of a traumatic injury to the cervical or lumbar spine. He disagreed with the impairment rating assigned by Dr. Lorio, since Claimant never had a cervical or lumbar injury. He opined that a Functional Capacity Evaluation (FCE) was not necessary because Claimant could return to his prior level of physical activity without limitations. (EX-B, p. 1).

Dr. Cenac observed that the FCE conducted by Dr. Bunch did not validate any organic basis for Claimant's professed level of pain or degree of disability, but rather revealed definitive objective signs of disability magnification behavior and non-organic signs. Despite his illness behavior, Claimant exhibited a physical ability to perform at the medium-heavy work level which is inconsistent. The FCE also disclosed that Claimant gave sub-optimal efforts and had no evidence of any injury or dysfunction of the musculoskeletal system. (EX-P, pp. 16-17).

Dr. Cenac further opined that a diagnosis of chronic soft tissue injury for Claimant is not valid because there is no evidence of mechanical dysfunction which would support any of his subjective complaints and in fact there was no evidence of

abnormal findings. (EX-P, p. 19). He opined that a disability impairment required substantial objective findings and physical findings which correlate to the subjective complaints raised and Claimant had neither. Id. Dr. Cenac further testified that Claimant does not need work hardening or physical therapy because he gave sub-optimal effort and still qualified for the medium-heavy work level.

Dr. Cenac testified that the FCE conducted by Ms. Mullins reveals her opinions that Claimant gave a good faith effort and that he did not have symptom magnification, but her testing revealed three positive Waddell signs which should have alerted her to Claimant's malingering/secondary gain attitude. (EX-P, p. 28). Dr. Cenac opined that Claimant had absolutely no permanent partial disability as a result of his work accident. (EX-P, p. 31).

Dr. A. John Tassin

Dr. Tassin was deposed by the parties on September 27, 2000. (EX-S). Dr. Tassin has been a general practitioner in Ville Platte, Louisiana since July 1970. (EX-S, p. 5). He examined Claimant on May 25, 1999, who reported a history of a work accident on May 11, 1999. He complained of neck pain, middle back pain, low back pain, right hip pain and numbness in his right leg. After a physical examination, Dr. Tassin diagnosed Claimant with a cervical and lumbar injury. He opined that Claimant had tenderness throughout his cervical spine and lumbar spine with decreased range of motion. Claimant exhibited a positive straight leg raising on the right and reported his right leg felt weak. He prescribed medications and, at Claimant's request, referred him to Dr. Razza, an orthopedist in New Orleans, but Claimant was unable to see Dr. Razza. (EX-S, p. 7; EX-H, p. 4)).

On June 15, 1999, Dr. Tassin again examined Claimant who was complaining of headaches, lower back pain and right hip and leg pain, but not neck pain. (EX-S, pp. 8, 14). Medications were re-filled. Claimant was referred to Dr. Morgan Lorio, an orthopedist. Claimant thereafter was treated by Dr. Lorio, but on September 2, 1999, returned to Dr. Tassin stating his right leg had given out and he had hit his right rib cage area. Dr. Tassin noted tenderness and complaints of his neck and lower back hurting, but found no objective signs of such injuries. Dr. Tassin prescribed a rib belt and medications but did not

treat Claimant again after September 2, 1999. (EX-S, pp. 9, 14, 18).

On cross-examination, Dr. Tassin testified that at the initial exam, muscle spasm, an objective finding, was not detected. (EX-S, p. 12). There was no muscle atrophy. He believed Claimant had sustained soft tissue injuries which should resolve over a period of a couple of weeks to a couple of months. (EX-S, p. 13).

Dr. Tassin treated Claimant for two car accidents. On March 29, 1994, Claimant presented with an injury to his sternum after hitting his chest on the steering wheel. Office notes indicate that Claimant sustained a back injury five years before which was a workers' compensation injury. (EX-H, p. 37). Dr. Tassin opined that he did not think Claimant had any residual disability as a result of the prior back injury. (EX-S, p. 21). On November 10, 1995, Claimant was involved in another car accident. The intake sheet prepared by Dr. Tassin's nurse on November 15, 1995, reflects Claimant complained of "right hip pain, right middle finger and right leg pain and lower back pain." (EX-H, p. 34). Dr. Tassin testified he did not note any complaints of back pain from Claimant during the exam, but rather pain in his pelvic area or right hip area. (EX-S, p. 23).

Dr. Tassin explained that the hip pain of which Claimant complained in 1999 was different from the 1995 pelvic/hip pain in that the former involved the hip and leg and the latter, the upper hip or pelvic area. (EX-S, pp. 23-24). Dr. Tassin testified that Claimant had no back pain or injury as a result of his November 10, 1995 car accident, and no residual disability. He treated Claimant on only one occasion for the 1995 car accident. (EX-S, p. 24).

Dr. Tassin testified that persons who work heavy manual labor and sustain injuries are more susceptible to degenerative problems in the future. He also stated that it was possible for the injuries sustained in the 1994 and 1995 car accident "to merge" with his 1999 work accident and "create a greater disability." (EX-S, p. 25). Dr. Tassin did not note any permanent partial disability on May 25, 1999. (EX-S, p. 27).

Dr. Morgan P. Lorio

Dr. Lorio, an orthopedic specialist, was deposed by the

parties on September 25, 2000. (EX-Q). Although the parties indicate Dr. Lorio's curriculum vitae is attached as an exhibit, the exhibit was not part of EX-Q. Dr. Lorio first examined Claimant on July 8, 1999, based on a referral from Dr. Tassin. Claimant presented with a major complaint of bilateral pain in the back on the right and left sides. (EX-Q, p. 6). Claimant's cervical spine was tender and he also complained of neck pain. On physical exam, Dr. Lorio observed a positive straight leg raising on the **left, causing tingling in the left leg**, and on the right in supine and seated positions. (EX-D, p. 15). Dr. Lorio diagnosed Claimant with "lumbar strain, cervical strain, probable right S-1 radiculopathy." He recommended a nerve conduction study and EMG. He opined Claimant should remain off work. (EX-D, p. 16). He opined Claimant had a soft tissue injury which can be disabling. (EX-Q, p. 7).

On August 18, 1999, Dr. Robert D. Franklin conducted an electromyographic study which revealed no definite evidence of neuropathy or radiculopathy noted by EMG/NCV of the right lower extremity. (EX-C, pp. 22-23).

On September 8, 1999, Dr. Lorio noted Claimant's continued complaints of neck problems and recommended an MRI because of the chronicity of his complaints. (EX-D, p. 14). On December 28, 1999, Dr. Lorio again examined Claimant who continued to complain of neck pain and headaches. He indicated that treatment of Claimant's back problems would be appropriately conservative. He stated he had nothing further to offer Claimant, apparently in the absence of compensation/medical clearance. (EX-D, p. 13).

On January 24, 2000, at the request of Dr. Lorio, a cervical myelogram and CT of the cervical spine were conducted at Opelousas General Hospital which were normal. (EX-F, p. 2).

On January 31, 2000, Dr. Lorio assigned a 4% impairment for Claimant's cervical spine (whole person) and a 7% impairment for the lumbar spine (whole person) based on the AMA Guides to Impairment. He opined Claimant was at maximum medical improvement (MMI) and could return to work at a level to be determined by a FCE. (EX-D, p. 12).

On February 15, 2000, Claimant returned to Dr. Lorio. It is noted that Claimant's CT myelogram appeared normal. Dr. Lorio's only recommendation with regard to the neck was more

therapy and a possible referral to a neurologist for "something in regard to his headaches." (EX-D, p. 11).

Dr. Lorio reviewed the FCE conducted by Ms. Mullins which concluded that Claimant could engage in maximum lifting/handling of 35 pounds, which he agreed was a reasonable recommendation. (EX-Q, p. 8). He stated that "soft tissue injuries resolve usually within a matter of weeks, and it's not that common for them to go beyond four months." (EX-Q, pp. 8-9). He opined that it is "possible" for a soft tissue injury to worsen over time. (EX-Q, p. 10). He opined that Claimant's injury was "more likely than not" caused by his work accident and is "permanent." He further opined that work hardening would not allow Claimant to return to his heavy offshore work. (EX-Q, p. 11).

On cross-examination, Dr. Lorio acknowledged that Claimant is not a surgical candidate and that his diagnostic test results have all been normal. (EX-Q, pp. 13-14). He considers a "disc problem" to be soft tissue and stated "I don't think we can prove that it's definitely not a disc, it's something in and about his spinal column." He affirmed that there is no gross abnormality or compression of nerve root demonstrated on any static image, but opined "there's some underlying something causing pain." (EX-Q, p. 15). Although his initial neurologic exam of Claimant suggested an S-1 problem, he admitted there is no study confirming his conclusion. (EX-Q, p. 17).

Dr. Lorio testified he placed Claimant at maximum medical improvement from a surgical standpoint as of December 28, 1999, however, after it was recommended that Claimant undergo a work conditioning/hardening program, he questioned whether Claimant had reached MMI. (EX-Q, p. 18). He opined that until Claimant completed a conditioning/hardening program, he remains in "limbo" and will not reach MMI until he completes a work hardening program. (EX-Q, pp. 20-21, 26; EX-D, pp. 8, 9). Work hardening has never been approved for Claimant. (EX-Q, p. 21). Dr. Lorio opined that work hardening "would be the most efficacious way to return [Claimant] back to work to a light activity level as indicated by FCE." (EX-D, p. 8).

The Functional Capacity Evaluations

Sandra Mullins, P. T.

Ms. Mullins, a physical therapist, was deposed by the

parties on September 25, 2000. (EX-R). She graduated from LSU School of Physical Therapy and has 25 years of experience as a therapist. (EX-R, p. 5). She established a private practice in Ville Platte, Louisiana, where she practiced physical therapy for 18 years. She has a Bachelor's Degree and is unpublished in the field of FCEs. (EX-R, pp. 13, 15). In 1990, she attended "a course on performing FCEs" and has been conducting FCEs since. (EX-R, pp. 14-15).

Ms. Mullins began physical therapy on Claimant on July 20, 1999, based on a referral from Dr. Lorio. (EX-R, p. 7). Claimant reported complaints of neck and back pain and informed Ms. Mullins that he had a "bad disc" at L5-S1. (EX-E, p. 51). Muscle spasm were noted in the bilateral lumbosacral area with negative straight leg raising. Id. Goals of improving spinal range of motion, decreasing muscle spasm and decreasing low back pain were established. (EX-E, p. 52).

Claimant attended therapy two to three times a week through October 14, 1999, with a main complaint of back pain radiating into his right leg. He reported several incidents of his right leg giving way. On his last visit, his gait had improved with no further episodes of his leg giving way and indicated he was 75% improved since beginning therapy. Claimant failed to return to therapy thereafter and was discharged on October 27, 1999. (EX-E, pp. 16, 20, 29).

Ms. Mullins administered a six-hour FCE on February 29, March 2 and March 6, 2000. (EX-E, p. 3). She concluded Claimant engaged in "good" effort and the test results had "fair validity." Abnormal findings were assigned in "kyphosis to lordosis" lifting which revealed poor correlation and inconsistency to static strength results and the "lift-pull index". (See EX-R, p. 38). A poor correlation was achieved in the perceived exertion (borg) and heart rate, indicative of an exaggeration of effort. (EX-E, p. 13). She opined Claimant was presently limited to the light activity level with maximum lifting and handling of 35 pounds. She recommended Claimant be placed in a work conditioning/hardening program with goals of improving function to the medium activity level. (EX-E, pp. 3-4). Ms. Mullins testified that Claimant tried with his best effort to perform the evaluation. (EX-R, p. 8).

Ms. Mullins was not aware of the results of the diagnostic testing performed on Claimant. (EX-R, pp. 17-18). She regarded Claimant's physical capacity between light to medium because of

his safe lifting capability. (EX-R, p. 28). He improved consistently throughout the period of his physical therapy. (EX-R, p. 31).

Dr. Richard W. Bunch, Ph.D.

Dr. Bunch was deposed by the parties on October 9, 2000. (EX-O). Dr. Bunch received a medical Ph.D. in the area of anatomy and neuroanatomy and served as an associate professor at the LSU Medical Center teaching at the graduate and undergraduate level. He also operated the orthopedic physical therapy clinic and taught anatomy courses to medical students. (EX-O, p. 6).

In 1993, Dr. Bunch established a private practice as Industrial Safety and Rehabilitation Institute. He developed his own functional capacity evaluation protocol called "Worksaver." He has conducted professional seminars in the United States and Europe in the prevention of muscular-skeletal injuries and has published a chapter entitled "A.M.A. Guides to Functional Capacity Evaluations" in the medical text The Handbook of Lower Extremity Neurology. (EX-O, p. 7). Dr. Bunch is board-certified in physical therapy, a certified ergonomic specialist and has conducted FCEs since 1985. (EX-O, pp. 8-9).

He conducted a FCE on Claimant on August 30, 2000 at the request of Counsel for Employer. (EX-O, p. 10; EX-A). Prior to the FCE, he reviewed various medical reports and records, including the results of the diagnostic testing performed. Id. The FCE consists of an intake interview; a comprehensive muscular-skeletal examination to determine postural abnormalities and muscle asymmetries, girth measurements to determine muscle atrophy or dysfunction; a neurological examination; range of motion, muscle strength, sensation, balance and coordination testing; and non-organic testing for Waddell signs. (EX-O, pp. 13-14).

Dr. Bunch classified Claimant's former work as a floorhand as heavy work, however Claimant was unable or unwilling to demonstrate sufficient residual functional capacities to safely return to his prior job. (EX-A, p. 2; EX-O, p. 16). Dr. Bunch testified that his job in a FCE is to determine if the level of disability is organic (caused by a physiological or pathological basis) or non-organic (no sufficient physiological reasons for the degree of disability or severity of symptoms presented). Claimant presented with reports of constant severe lower back

pain walking with a cane and reported intermittent pain radiating down the back of his right leg. Despite his reports of right leg pain and weakness, Dr. Bunch observed Claimant had well-developed leg muscles with normal muscle tone and no evidence of muscle atrophy.

After testing, his overall impression was that there were no significant results to validate an organic basis for Claimant's level of pain or his degree of disability. Claimant's entire physical examination was completely negative for impairments.¹² (EX-O, pp. 17-18; EX-A, p. 1). The neurological and muscular-skeletal exams were also negative. Special tests conducted failed to support any consistent or reliable objective signs of myelopathy or neuropathy that would account for Claimant's reported right leg pain. (EX-A, p. 1).

Dr. Bunch noted that psychometric testing revealed Claimant to have a self-perception of severe disability and on employability queries indicated poor motivation to return to work. He was observed inconsistently limping at one point and not limping at other times during the examination. Other key inconsistencies or contradictory findings included: an inability to stand for more than three minutes and 23 seconds during standing postural tests, but standing for much longer periods between tests (EX-O, pp. 39-40); an inability to squat for more than one minute and 14 seconds despite normal lumbar and hip range of motion (EX-O, pp. 40-41); and positive supine straight leg raising for the right leg, but negative sitting straight leg raising (EX-O, pp. 41-42).

Claimant exhibited positive findings on four of five Waddell signs which is consistent with non-organic illness behavior according to Dr. Bunch, along with nineteen other signs indicative of illness behavior. (EX-O, pp. 21-22). He explained that Waddell signs are test designed to determine if there is an organic basis for subjective complaints. Positive signs indicate a high probability that there is a non-organic or

¹² Dr. Bunch noted that Claimant arrived at the clinic with a reported level of pain of 7 of 10, considered "pretty severe," and upon completion of the FCE reported a very severe, almost intolerable pain level of 9 of 10. However, inconsistently and contradictorily, there were no corresponding significant change in heart rate or systolic blood pressure readings. (EX-O, p. 19).

non-physiological basis for complaints, which may represent malingering for secondary gain, symptom magnification or psychological or psychosomatic disorders. (EX-O, p. 23). In Claimant's case, the magnitude of his symptoms were out of proportion to the physiological findings and the overwhelming evidence revealed he was not as disabled as he portrayed and his symptoms were not as severe as he stated. (EX-O, pp. 23-24). Despite such behavior, Claimant demonstrated a physical capability level classified at the medium level with partial capacity for heavy work, both of which were self-limited due to pain, which was a subjective complaint of Claimant. (EX-O, pp. 19-20, 33; EX-A, p. 2).

The Vocational Evidence

Glenn Hebert

Mr. Hebert was deposed by the parties on November 3, 2000. (CX-14). He has earned a Master's Degree in vocational counseling and is a certified vocational rehabilitation counselor. (CX-14, p. 5). He interviewed Claimant and rendered a report of his vocational assessment on September 26, 2000. (CX-11).

Mr. Hebert administered a Wide Range Achievement Test to assess Claimant's functioning in reading, spelling and arithmetic. The testing revealed Claimant functioned at the second grade in reading, first grade in spelling and fourth grade in arithmetic and was basically functionally illiterate. (CX-11, pp. 1-2; CX-14, p. 6). He agreed with the conclusion reached by Dr. Stokes that Claimant was moderately mentally handicapped. (CX-14, p. 7).

Mr. Hebert testified that a floorhand is considered heavy to very heavy work according to the Dictionary of Occupational Titles because of a lifting requirement of 50 to 100 pounds throughout the work day. (CX-14, p. 8). He opined, based on his review of the medical evidence and FCEs, that Claimant will not be able to return to unrestricted heavy manual labor, which includes his former job as a floorhand. (CX-11, p. 4). He further opined Claimant would have a lot of problems finding work and would probably only find part-time work earning \$5.15 to \$6.00 per hour. (CX-14, p. 11).

He disagreed with Dr. Stokes' opinion regarding alternative jobs identified in Lafayette, Louisiana because of the one-way

driving distance from Ville Platte of 53-55 miles. He opined that it was not economically feasible to drive 53-55 miles, which he estimated would take one hour and fifteen minutes, to obtain a job which paid \$6.00 to \$7.00 an hour. (CX-14, pp. 12, 20). He also stated that jobs in Alexandria, Louisiana were inappropriate because of the 63 mile distance one way from Ville Platte. (CX-14, p. 24). He further opined that Claimant would probably only earn minimum wage for the rest of his life if he can only do light work and with his limited educational background. (CX-14, pp. 13-14).

Mr. Hebert testified that his opinions were based upon Claimant's ability to perform light to medium work. He stated Claimant had a better chance of obtaining work if he can perform medium work because such work requires more physical than intellectual ability. He did not think Claimant would find work in the light work range because he can not read or write or operate a computer. (CX-14, p. 18). He testified he placed greater weight on the opinion of Claimant's treating physician, Dr. Lorio, that Claimant can perform light work than on the results of the FCEs until Dr. Lorio adopts the conclusions reached by Ms. Mullins or Dr. Bunch. (CX-14, p. 19).

Dr. Larry Stokes, Ph.D.

Dr. Stokes, who earned a Ph.D. in rehabilitation counseling, testified at the hearing on behalf of Employer. He is board-certified and licensed in vocational rehabilitation counseling. (Tr. 188-189). He was accepted as an expert in the field of vocational rehabilitation counseling. (Tr. 189).

Dr. Stokes interviewed Claimant on October 3, 2000 and rendered a report on October 10, 2000. (EX-G). He was assigned to determine Claimant's rehabilitation employability and wage-earning capacity. He conducted achievement, intelligence and interest testing. (Tr. 190). He noted Claimant had completed the seventh grade of formal education, but had repeated the third and fifth grades and left school to go to work. (Tr. 191). Based on his test scores, Dr. Stokes considered Claimant to be moderately mentally handicapped. (Tr. 228). However, based on Claimant's past employment experiences and aptitudes, he opined Claimant's general intelligence was at the average level. (Tr. 192).

Dr. Stokes opined, based on his review of the medical evidence and FCEs, that if the opinions of Drs. Cenac and Bunch

were accepted, Claimant could return to his former employment as a floorhand, which is classified as heavy work, with no loss of wage earning capacity. (Tr. 203, 207).

Dr. Stokes prepared a labor market survey dated October 10, 2000 identifying ten light to medium open jobs. (Tr. 211-212; EX-G, pp. 6-7). He provided employers with a "profile" of Claimant's background and asked if they would consider Claimant for employment, to which they responded he "could be" considered. (Tr. 213). Although he sought approval of each job by corresponding with Drs. Cenac, Tassin and Lorio, none of the physicians responded. (Tr. 218; EX-G, pp. 9-25). He noted that Dr. Lorio opined Claimant would not be at MMI until he completed a work hardening program, but did not preclude Claimant from work. (Tr. 215, 217).

Of the nine jobs identified for physician approval, seven were located in Lafayette, Louisiana, which Dr. Stokes estimated to be 45 miles from Ville Platte. (Tr. 233). He was aware Claimant had no driver's license, but did not consider that to be a barrier to employment because Claimant reported he drove without a license. Tr. 231). He excluded possible jobs in Alexandria, Louisiana because it is 50 miles from Ville Platte, which exceeded his 45 mile radius guideline used for job searches. (Tr. 235).

The nature of the work involved and the physical requirements of each job are not noted in the labor market survey or the letter to Claimant. (EX-G, p. 9). However, the letters addressed to the treating and consulting physicians generally note the nature of the duties and physical demands of the identified jobs. (EX-G, pp. 11-15).

The Surveillance Evidence

Four video surveillance tapes were offered by Employer. The first surveillance video was made on July 8, 1999, the last on October 6, 2000, sixteen months later. (EX-N). Only portions of six days are reflected in the four videos.

On July 8, 1999, Claimant is filmed walking to Dr. Lorio's office at 9:17 a.m., but no cane. He leaves the office and departs in his car at 11:24 a.m. At 11:46 a.m., Claimant is depicted standing outside his attorney's office smoking a cigarette. At 11:50 a.m., he enters the attorney's office. At 3:45 p.m., Claimant is seen bending over in his yard and then

using a screwdriver overhead with both hands on a wooden gate. At 4:41 p.m., he is depicted leaving a tobacco store and entering his car. (Tape 1, EX-N).

On June 15, 1999, Claimant is seen removing a weed eater from the trunk of his car as well as a lawnmower. He cut his lawn, pushing and pulling the mower back and forth for only two minutes on the video. (Tape 2, EX-N).

On February 26, 2000, Claimant is filmed exiting an Express Lane store, entering his car and driving away at 9:57 a.m. On February 27, 2000, at 10:57 a.m., Claimant is filmed walking to a Chevron store without a limp or cane. He is filmed outside his home at 11:25 a.m., directing a man to move a charcoal barrel-grill into his garage. At 11:28 a.m., another man assists Claimant by removing from his car trunk and carrying a large bag of charcoal and two other smaller bags while Claimant carried one smaller bag into the garage. At 11:39 a.m., Claimant is depicted sitting on his porch and thereafter pushing himself up off the porch. The remainder of the video is uneventful. (Tape 3, EX-N).

On October 5, 2000, Claimant is filmed exiting a red car at 4:13 p.m. and walking into his garage without a limp or cane. At 4:14 p.m., he walked to a next door car wash without a limp. At 4:15 p.m., he returns to his home and briskly steps up his door steps. At 4:28 p.m., Claimant is filmed one-handedly placing a large jug into the back seat of his car. At 4:55 p.m., Claimant unloaded two large jugs from his car and carries them, one in each hand into his garage without a limp. On October 6, 2000, Claimant is filmed at 10:07 a.m. leaving an Ace Hardware store with a bag. The remainder of the video is uneventful. (Tape 4, EX-N).

The Contentions of the Parties

Claimant contends that he is permanently totally disabled from returning to his former job as a floorhand because of his back, neck and hip injury of May 11, 1999. He argues that Dr. Tassin took him off work on May 25, 1999 and instructed him not to drive long distances, e.g. to Houma, Louisiana, of which Employer had knowledge, therefore, he was not eligible to return to work on May 31, 1999, and so informed Employer.

Claimant claims that the stipulated average weekly wage of

\$509.60 was actually his compensation rate and that his weekly wage was \$765.16 as calculated on CX-3.

Alternatively, Claimant contends he was temporarily totally disabled from May 11, 1999 to January 31, 2000, when Dr. Lorio opined he could return to light work. He further argues he is entitled to permanent partial disability benefits from January 31, 2000, and continuing based on a wage earning capacity of \$240.00 per week and a \$351.86 weekly difference from his average weekly wage.

Employer contends that Claimant alleges an unwitnessed accident causing injury to his back, hip and neck for which Dr. Cenac could find no physical basis and no disability. Employer asserts Claimant was a voluntary termination on May 31, 1999 when he failed to return to the TEP program for light duty. Employer argues that Claimant is incredible and inconsistent in his testimony at hearing and in deposition displaying a "blatant willingness to stretch the truth." Employer claims entitlement to Section 8(f) relief based on a combination of Claimant's prior back and hip injuries and the instant job injuries, if Claimant is awarded disability benefits.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551

F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

A. Claimant's Credibility

An administrative law judge has the discretion to determine the credibility of witnesses. Furthermore, an administrative law judge may accept a claimant's testimony as credible, despite inconsistencies, if the record provides substantial evidence of the claimant's injury. Kubin v. Pro-Football, Inc., 29 BRBS 117, 120 (1995); see also Plaquemines Equipment & Machine Co., v. Neuman, 460 F.2d 1241, 1243 (5th Cir. 1972).

Employer relies upon inconsistencies between Claimant's testimony, deposition and portions of the medical evidence which it asserts supports a finding of a lack of credibility. Employer contends Claimant's testimony should be discredited because there were no eyewitnesses to his work accident and the medical condition which forms the basis of Claimant's alleged disability consists of subjective complaints of pain.

There are a myriad of factors diminishing the credibility of Claimant's testimony in this matter. I am not persuaded by Claimant's argument that he is uneducated, practically illiterate and borderline mentally handicapped as justification for his demeanor, contradictory testimony and inconsistent reports to treating and consulting physicians. Claimant clearly understood the questions posed to him at hearing and responded thereto. Based on his prior work experience, Dr. Stokes opined Claimant's general intelligence was at the average level. I find that Claimant's hearing testimony was generally equivocal, ambiguous, incredible and unpersuasive when correlated internally with statements made at his deposition. A brief discussion of the most significant discrepancies follows.

Claimant's case began with an allegation that he injured his neck in his job accident. He did not report such an injury when providing information for his accident report the following morning. His explanation for omitting the information was the neck complaints began after the report was completed. He claims he reported neck complaints to Dr. Cenac on his first visit on May 14, 1999, however Dr. Cenac's office notes do not reflect such complaints, nor does Dr. Cenac recall such complaints. Ms. Duplantis, who accompanied Claimant to the visit, disputes Claimant's version of the complaints and denies he informed Dr.

Cenac of neck problems. Moreover, Claimant did not report neck complaints on his second visit to Dr. Cenac according to office progress notes. Ms. Larke supports Claimant's failure to mention neck pain to Dr. Cenac on the second visit. Although Claimant reported subjective neck complaints to Dr. Tassin and Dr. Lorio, the record fails to objectively support a cervical injury to Claimant. Therefore, I do not accord any weight to Claimant's testimony that he injured his neck in his job accident.

Claimant was not forthright in his deposition testimony concerning prior injuries. He denied ever having problems with or injuries to his back, hip or legs before his job accident. He stated he was involved in only one auto accident (1994), but actually had a second accident in 1995. Dr. Tassin testified that Claimant made no back complaints after the 1995 auto accident, contrary to his intake records, however confirmed Claimant had prior injuries to his right hip and symptoms involving the right leg. At hearing, Claimant acknowledged his prior injuries to his right hip and leg which is contrary to his deposition.

In deposition, Claimant denied performing any work since his accident, but recanted stating that he earned cash for "DJ work" and also performed repairs on his house for his landlord in exchange for rent, such as repairing a hinge or latch on a gate. He denied lifting his lawnmower, however, video surveillance clearly depicted him doing so. He stated the heaviest objects lifted were his 18.5 pound DJ speakers, but was filmed carrying water jugs in each hand which weigh approximately 42.5 pounds each. He denied he had the ability to make repairs which required him to reach overhead, but video surveillance clearly showed him doing such with both hands over his head. Such inconsistencies buttress a finding of a total lack of credibility.

Claimant's efforts during the two FCEs disclose exaggeration, submaximal effort, symptom magnification and no objective evidence of a physiological impairment. Ms. Mullins stated Claimant reported he had a "bad disc," which is clearly not supported by the medical evidence of record. Only a "fair validity" was ascribed to her FCE results because subjective components produced abnormal findings. Dr. Bunch found four of five Waddell signs positive and nineteen other non-organic illness behavior and self-limitation instances which are reflective of inconsistencies and contradictions in Claimant's

presentation. Dr. Bunch concluded there existed no organic basis for Claimant's level of pain or disability. The foregoing FCE conclusions belie Claimant's subjective complaints.

In sum, I find Claimant had little regard for his oath and was incredulous on many factual matters which detracts from the weight, if any, to be accorded his testimony and his claim in general.

Notwithstanding these internal inconsistencies and contradictory statements, I will analyze whether Claimant established a **prima facie** claim for compensation and whether the medical evidence of record rebuts the Section 20(a) presumption, provided the presumption invocation has been met.

B. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary-that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which **could have caused** the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

1. Claimant's Prima Facie Case

The parties stipulated Claimant was involved in an "incident" on May 11, 1999, during the course and scope of his employment with Employer.

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT)(5th Cir. 1982).

Claimant testified that he suffered a harm or pain and that conditions existed at his work site which could have caused the harm or pain, when the ladder upon which he was standing slid out from under him causing him to spring up hitting his back and hip on a trough and leaving him suspended by his safety harness. In light of the liberal construction of the Act, and based on the stipulations of the parties, Claimant presented sufficient evidence to meet the threshold issue that he suffered a harm and injury to his body as a result of the May 11, 1999, "incident." Thus, Claimant has established a **prima facie** case sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

2. Employer's Rebuttal Evidence

Once Claimant establishes a **prima facie** case, the burden shifts to the employer to rebut the presumption with substantial countervailing evidence that Claimant's condition was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT)(5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT)(5th Cir. 1998); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT)(5th Cir. 1994). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. Avondale Industries v. Pulliam, 137 F.3d 326, 328 (5th Cir. 1998).

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand

Terminal, 14 BRBS 844 (1982). Rather, the presumption must be rebutted with **specific and comprehensive medical evidence** proving the absence of, or severing, the connection between the harm and employment. Hampton v. Bethlehem Steel Corp., 24 BRBS 141, 144 (1990). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

When aggravation of or contribution to a pre-existing condition is alleged, the presumption still applies, and in order to rebut it, Employer must establish that Claimant's work events neither directly caused the injury nor aggravated the pre-existing condition resulting in injury or pain. Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986). A statutory employer is liable for consequences of a work-related injury which aggravates a pre-existing condition. See Bludworth Shipyard, Inc. v. Lira, 700 F.2d 1046 (5th Cir. 1983); Fulks v. Avondale Shipyards, Inc., 637 F.2d 1008, 1012 (5th Cir. 1981). Although a pre-existing condition does not constitute an injury, aggravation of a pre-existing condition does. Volpe v. Northeast Marine Terminals, 671 F.2d 697, 701 (2d Cir. 1982). It has been repeatedly stated employers accept their employees with the frailties which predispose them to bodily hurt. J. B. Vozzolo, Inc. v. Britton, supra, 377 F.2d at 147-148.

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Employer relies upon the opinions of Dr. Cenac that no evidence of recent trauma or an injury was detected when Claimant was examined on May 14 and 19, 1999. Dr. Cenac who noted only tenderness, a subjective response by Claimant during examination, concluded that Claimant's neurological and radiographic evaluations were normal and the magnitude and intensity of his subjective complaints could not be substantiated by any objective physical findings. Dr. Cenac opined, after diagnostic tests were conducted and resulted in normal findings, that Claimant had no disability or injury. Dr. Cenac questioned the validity of Claimant's subjective complaints. Based on the foregoing, I find that Employer has presented specific medical evidence rebutting Claimant's **prima**

facie case that a harm was sustained from the May 11, 1999 "incident."

Having determined that Employer met its burden of rebuttal, it is necessary to weigh all of the medical evidence and resolve causation based on the record as a whole.

Dr. Cenac was the first physician to treat Claimant after his accident. He observed no bruises or contusions on Claimant's hip or spinal area. Claimant reported tenderness, a subjective symptom, in the hip area, but Dr. Cenac observed no abrasions or contusions. Claimant's physical, neurological and radiographic evaluations were normal. X-rays of his right hip revealed calcification about the acetabulum of the pelvis, which Dr. Cenac opined was consistent with an old injury, but Claimant denied any prior history of injury. Contradictorily, Dr. Tassin's records reveal that Claimant injured his right hip in his 1995 auto accident. Dr. Cenac found no evidence of recent trauma or injury from Claimant's alleged work accident. He returned Claimant to full duty.

On his second visit to Dr. Cenac, Claimant complained of numbness in his right foot and increasing lower back pain. Dr. Cenac could not substantiate the magnitude or intensity of Claimant's subjective complaints with any objective findings. Claimant had normal neurological and mechanical findings, normal straight leg raising and hip exam and no evidence of any anatomical reason why he was complaining of his professed symptoms. Dr. Cenac gave Claimant the benefit of the doubt and ordered an MRI and bone scan. Both diagnostic tests were normal, evidencing no trauma to the body, soft tissue or skeletal areas. Dr. Cenac returned Claimant to duty.

Dr. Cenac opined Claimant's symptoms were suspect and he was malingering. He opined Claimant had no disability or injury even though he released him to light duty pending testing. He confirmed that Claimant never complained of neck problems unlike the complaints made to Dr. Tassin. He also affirmed that Claimant never complained of left leg problems as he had reported to Dr. Lorio. His review of the cervical myelogram and CT study confirmed normal test results. He disagreed with Dr. Lorio's assigned impairment ratings and diagnosis of soft tissue injury because Claimant had no physical or objective findings, no injury or mechanical dysfunction, but only normal findings.

Dr. Bunch, who is more highly credentialed than Ms. Mullins,

opined there were no significant results from Claimant's FCE to validate an organic basis for his professed level of pain or disability. Claimant's entire physical examination was considered negative for impairments. Neurological and muscular-skeletal exams were normal. Moreover, special testing failed to reveal any myelopathy or neuropathy to account for Claimant's right leg pain. Claimant's right leg was well-developed with normal muscle tone and no evidence of muscle atrophy. Claimant exhibited numerous inconsistencies and contradictions in his presentation as detailed above which formed the basis of Dr. Bunch's conclusion that he was magnifying or exaggerating his symptoms. Despite the foregoing, Dr. Bunch opined Claimant could perform medium to heavy work. I place more probative value on Dr. Bunch's FCE results than on the FCE conducted by Ms. Mullins. The meticulous detail and protocol set forth in Dr. Bunch's report provides substantially more information and reliable data than the report of Ms. Mullins. Ms. Mullins also found Claimant exhibited positive signs of exaggeration and abnormal findings. Moreover, she relied upon Claimant's report of a "bad disc" and was not aware, nor did she review the results, of any of the normal diagnostic tests conducted on Claimant. I discount value of her opinions and report/results because of a lack of or incorrect underlying medical information.

The medical evidence and diagnoses proffered in support of Claimant's case are based solely on Claimant's subjective complaints. Although various diagnostic tests, to include x-rays, lumbar and cervical myelograms, a CT study post-myelogram, a bone scan and EMG/NCV studies, were conducted to determine the nature and extent of Claimant's injuries, none yielded any objective findings of trauma or injury. Dr. Tassin, a general practitioner, acknowledged that he found no objective signs of injury when he examined Claimant. Only Claimant's subjective complaints of tenderness, reduced range of motion, an inconsistent positive straight leg raising test and leg weakness were noted. Dr. Tassin found no muscle spasm or atrophy.

As noted by Dr. Cenac, no mechanical dysfunction was observed or reported by Dr. Tassin to support a diagnosis of soft tissue injury. I place more probative weight on Dr. Cenac's reasoned opinion than the conclusions reached by Dr. Tassin, which are based purely on Claimant's reported history and subjective symptoms that are marred by incredulity.

Dr. Lorio's diagnosis is also unsupported by the medical evidence. He received subjective complaints of tenderness and right and left back pain. Claimant reported straight leg

raising caused tingling in his **left** as well as his right leg. Dr. Lorio also acknowledged no objective findings existed in support of Claimant's complaints. All diagnostic tests conducted at Dr. Lorio's request were also normal.

Although Dr. Lorio assigned impairment ratings for Claimant's lumbar and cervical spine, Dr. Cenac disputed any impairment ratings because of a lack of mechanical dysfunction. The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition (2001) at page 383, recommend that physicians document physiologic and structural impairments relating to injuries when assigning impairment. Moreover, impairment ratings should be based on the condition once MMI is reached and not on prior symptoms or signs. Id. No physiologic or structural impairments have been established based on the objective evidence in this record. Thus, I accept the conclusions of Dr. Cenac, whose opinions are more rationally based on an absence of objective evidence, rather than Dr. Lorio's, whose opinions are not objectively supported by the record.

3. Conclusion

Thus, weighing all of the medical evidence of record, as well as the inconsistent and equivocal testimony of Claimant, I find and conclude that Employer has successfully produced **specific and comprehensive medical evidence**, namely findings based on objective medical data, that refute any connection between Claimant's alleged accident and his employment. As previously noted, a claimant's testimony may be accepted despite inconsistencies and contradictions **if** the record provides substantial evidence of claimant's injury. I find it does not based on the instant record. Accordingly, I further find and conclude Claimant failed to establish a crucial element of his **prima facie** case, i.e., that he suffered a work-related injury on May 11, 1999. Therefore, because Claimant has not met his burden of proof, he is not entitled to the Section 20(a) presumption. See Director, OWCP v. Greenwich Collieries, supra.

In view of the foregoing findings and conclusion, the

remaining unresolved issues of nature and extent, average weekly wage, Claimant's wage earning capacity and Employer's entitlement to Section 8(f) relief, are rendered moot.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

Claimant's claim for compensation and medical benefits under the Act is hereby **DENIED**.

ORDERED this 29th day of June, 2001, at Metairie, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge